State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

STAR Grant Program

Discretionary Funds Application

Applicant:		Date of Birth:
Address:		
City:	State:	Zip code:
Telephone:	Email address:	
Person completing form:		Telephone:
Relationship to applicant:		
Date of Request:	Amount of request: $	
Describe items, services, or payments requested. *Attach supporting documentation, e.g., estimate from vendor, catalog page/order, written recommendation of health care professional, or copies of bills*		
Vendor or service provider name:		
Address:		
Telephone number:		
STAR agency:		
Request reviewed by ☐ STAR Coordinator ☐ STAR Advisory Board		
☐ Approved	Date:	Amount: $
Approved by:		
Comments/Plan:		
☐ Denied	Date:	Amount: $
Denied by:		
Reason for denial:		